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INFORMATION MEMO FOR CHARGE d'AFFAIRES THOMAS HASTINGS, ZIMBABWE

FROM: S/GAC – Acting U.S. Global AIDS Coordinator, Principal Deputy Assistant Secretary, Dr. Angeli Achrekar, DrPH, MPH

THROUGH: Therese Wingate, Chair and Jennifer Cole, PEPFAR Program Manager

SUBJECT: Fiscal Year (FY) 2023 PEPFAR Planned Allocation and Strategic Direction

Dear Chargé Hastings,

First and foremost, I sincerely hope that you and your team are safe and healthy. I am extremely grateful for your ongoing leadership of the PEPFAR program and additional COVID-19 response efforts during this difficult year.

While countries around the world continue to manage the effects of the COVID-19 pandemic, and the U.S. government acts on its commitment of support, it is encouraging to see vaccines making their way around the globe. The COVID response efforts – and continued use of the PEPFAR platform to support testing and vaccine delivery and uptake at point of care settings - are essential to our ability to provide ongoing care and life saving support for people living with HIV. The PEPFAR program has faced many challenges as a program during this period. Nevertheless, the PEPFAR family and partners have carried the mission forward while enduring significant personal impacts of COVID-19. Despite these challenges, what remains true is the strength and resilience of PEPFAR in partnership with countries and communities – through our teams, and our programs in the midst of dueling pandemics

Tremendous effort has been made by PEPFAR over the year to protect and accelerate the HIV gains, while leveraging the platform to respond to COVID-19 as well.

PEPFAR Country/Regional Operational Plan (COP/ROP 2022) (for implementation in FY2023) represents a pivotal year in PEPFAR, as several countries are reaching or approaching the agreed upon UNAIDS 95/95/95 benchmarks for attaining epidemic control. As countries approach these benchmarks, while pivoting from "scaling to close gaps" to "sustaining" epidemic control, we must ensure HIV program and population equity, address outstanding barriers that threaten to derail progress made in reducing new HIV infections and associated mortality, and tailor our programs to serve all populations.

This year it is particularly important to plan COP/ROP22 together with the country government, civil society, and multilateral partners. Across PEPFAR, the focus on equity requires vigilant attention to program data demonstrating results and gaps. A focus on equity also means a focus on population groups where our efforts to date have not closed gaps, and specific planning, resource allocation, and program

tailoring are needed – depending on what the data reveal for each country – focusing on: children, adolescent girls and young women, and key populations.

While implementation continues, or in many cases, has started to scale up, most PEPFAR countries are on a path to achieving program coverage goals. With that in mind, PEPFAR programs should focus on four key themes as we approach COP/ROP 22 planning and implementation:

1. Achieve and sustain epidemic control using evidence-based, equitable, people-centered HIV prevention and treatment services.
2. Support resilient and capacitated country health systems, communities, enabling environments, and local partners to build enduring capabilities.
3. Strengthen cooperation and coordination for greater impact, burden sharing, and sustainability.
4. Employ an equity lens with a persistent focus on reducing persistent inequalities experienced by children, key populations, and adolescent girls and young women.

I want to applaud the PEPFAR team for:

- Maintaining adults on treatment and expanding TX_CURR during significant COVID-19 disruptions throughout the year. National coverage of people living with HIV continued to advance with overall high linkage rates, and continued improvement in viral load suppression among adults.
- Advancing prevention interventions in challenging circumstances with continued focus on adolescent girls and young women increasing primary package completion rates in DREAMS, expanded PrEP access and use among vulnerable populations, and a successful age pivot with 100% of VMMCs conducted among clients 15 years of age or older.
- Engaging the Global Fund, Zimbabwe's Ministry of Health and Child Care and other partners in a critical effort to complete additional data collection and initial analysis of human resources for health (HRH) beyond the first HRH Inventory process.

Together with the Government of Zimbabwe and civil society leadership we have made tremendous progress together. Zimbabwe should be proud of the progress made over the past 18 years of PEPFAR implementation and we are deeply grateful for the ongoing deep coordination with the Global Fund and UNAIDS.

As you will see in COP guidance this year, changes in program direction will vary depending on where countries are in reaching epidemic control and the continued COVID-19 mitigations efforts each team is facing. While assessing possible shortfalls in programming arising from COVID-19, overarching challenges still exist.

Specifically, more focus and attention should be given to the following key challenges in PEPFAR Zimbabwe:

1. Overall viral load coverage (VLC) continued to increase with a comprehensive approach yet remains under optimal levels with commodities stock challenges and systems investment gaps.
2. Pediatric viral load suppression (VLS) improved in FY21, however VLS remains below adult rates at 79%, and FY21Q4 data noted pediatric Nevirapine still being dispensed. It is important to complete transition to DTG-based regimens for children and adolescents living with HIV (C/ALHIV) regardless of VL availability/results and ensure the OVC program which exceeded

targets in FY21 has optimal alignment of OVC programs and target allocation with geographic burden of C/ALHIV.

3. TB screening and reporting practices should be optimized. The proportion of screen-positive patients has been consistently low, and based on WHO estimates, close to 60% of the estimated incident TB cases were undiagnosed in FY21 among PLHIV supported by PEPFAR in Zimbabwe. Though TPT completion rates increased, coverage should continue to expand.

A fuller set of details, including funding earmarks and specific program direction are included in the accompanying COP/ROP 22 PEPFAR Planned Allocation and Strategic Direction Summary.

Consistent with the approach from years past, PEPFAR teams will once again be responsible for setting their own targets across PEPFAR program areas (with the treatment current target no less than the result that was to be achieved in COP 2021) in consultation with stakeholders. Teams should bear in mind that PEPFAR targets are not PEPFAR's but flow directly from the partner country government's commitment to the UNAIDS and SDG 3 goals.

The PEPFAR COP/ROP 22 notional budget for Zimbabwe is **$203,800,000** inclusive of all new funding accounts and applied pipeline. All earmarks and program directives provided below must be met. Targets and the subsequent approved budget should reflect the level of ambition the PEPFAR team, in collaboration with the Government of Zimbabwe and civil society of Zimbabwe, believes is critical for the country's progress towards controlling the pandemic and maintaining control.

Finally, in alignment with efforts by the U.S. government to support diversity, equity, inclusion, and accessibility as well as to advance equity for underserved communities and prevent and combat discrimination or exploitation on the basis of race, religion, gender identity or sexual orientation, PEPFAR will work to ensure that these principles are upheld, promoted, and advanced in all PEPFAR programs and in how we do business.

Please note that within the next few days our PEPFAR Chairs and PEPFAR Program Managers (PPMs), working closely with our CAST teams, will review this planning letter and details contained, herein, with your wider PEPFAR country team. Stakeholder engagement is essential for a productive and impactful planning process, and civil society engagement will continue to be an integral part of this planning process. Included in this planning letter is an outline of the expectations for engaging key stakeholders and civil society, as we continue to finalize our approach to hosting a virtual COP/ROP22 planning and approval process.

Once again, thank you for your continued leadership and engagement during the COP/ROP22 process.

Sincerely,

Angeli Achrekar

Attachment: **COP/ROP 2022 PEPFAR Planned Allocation and Strategic Direction Summary.**

CC: **S/GAC – Therese Wingate (Chair), Jennifer Cole (PPM) and Kristine Clark (PEPFAR Country Coordinator)**

Overview: COP/ROP 2022 PEPFAR Planned Allocation and Strategic Direction

With input from the field teams through the quarterly monitoring POARTs, as well as Headquarters Country Accountability and Support Teams (CAST) input, a thorough program review of your country over time has been conducted. This includes the end of year results of the Country Operational Plan (COP) 2020 and current COP 2021 implementation as we plan for COP 2022. We have noted the following key successes and challenges:

Successes

1. The program achieved 92% of target in TX_CURR and total has grown quarterly across all agencies for the past 8 quarters. The program has also achieved high coverage of estimated PLHIV in the country with overall proxy linkage rates over 94% and continued improvement in viral load suppression among adults. These achievements are remarkable given the significant challenges Zimbabwe has experienced from COVID-19, HRH issues, clinic closures, and economic issues.
2. Prevention interventions advanced with a continued focus on adolescent girls and young women achieving increased primary package completion rates in DREAMS, including over 80% in districts newly initiating DREAMS in FY21. PrEP access and use expanded among adolescence girls and young women (AGYW) and key populations, surpassing COP20 targets at 166% for PrEP_NEW and 168% for PrEP_CURR. Additionally, the team managed a successful age pivot with 100% of VMMCs conducted among clients 15 years of age or older, and while under target the program increased VMMCs each quarter through FY21 during COVID.
3. The Key Populations (KP) Program exceeded KP_PREV targets, expanded HIV self-testing, and met 98% of KP TX_NEW targets using social network testing strategies, increased community HIV self-testing distribution, increased focus on capacitating public sites to be KP competent, community initiation and commodities dispensation, same day ART initiation, enhanced peer navigation and other DSD services.
4. The majority of TB patients were tested for HIV in FY21, maintaining pre-COVID levels of 97%. PEPFAR Zimbabwe also was able to maintain treatment adherence among TPT clients with 91% of those who initiated TPT completing their treatment. Moreover, the high GeneXpert usage for TB diagnostics leads among PEPFAR OUs.
5. The team successfully coordinated with the Global Fund, Zimbabwe's Ministry of Health and Child Care (MoHCC) and other partners to complete additional data collection of health workers not funded by PEPFAR and initial analysis of human resources for health Inventory results has begun. This included noting 53% of PEPFAR-supported healthcare workers (HCW) provided support for the COVID-19 response, over 50% of HCWs supported by PEPFAR are community health workers, over 50% of HCWs supported by PEPFAR work at the site-level on care and treatment, and 15% of total HCWs supported and 42% of HRH expenditures are in Harare to help inform further detailed review and strategic planning for efficient resource allocation.

Challenges

1. Overall viral load coverage continued to increase with a comprehensive approach yet remains under optimal levels with commodities stock challenges and systems investment gaps that will require a multi-year strategy and strong partnerships with Global Fund, the Government of Zimbabwe, and others to mobilize and coordinate resources to address priority interventions.
2. Pediatric viral load suppression improved in FY21, however VLS remains below adult rates, with VLC is at 55%, and FY21Q4 data noted pediatric NVP still being dispensed.

3. TB screening and reporting practices should be optimized. The proportion of screen-positive patients was consistently low (1.3%) in 2021 versus expected 10-15%. Based on WHO estimates, close to 60% of the estimated incident TB cases were undiagnosed in FY21 among PLHIV supported by PEPFAR in Zimbabwe. TPT coverage may also be improved by scaling up IPT and implementing alternate regimens.

Given your country's status of achieved or are near achieving epidemic control, the following priority strategic and integrated changes are recommended:

- Accomplish the mission and sustain gains, including a focus on using community led monitoring (CLM) and triangulating data to address barriers to treatment continuity plus reinforce data quality that is necessary to understand and optimize continuity of treatment and to identify vulnerable populations who have truly fallen out of care.
- Continue working closely with the Global Fund to address commodity forecasting and funding needs while ensuring alignment on key priorities – particularly for human resources for health support and viral load testing coverage and suppression.
- The remarkable amount of data now available on human resources for health support will be essential to begin planning how best to address the health system's reliance on PEPFAR supported HRH and harmonize approaches across donors and government of Zimbabwe for remuneration and achieving local responsibility for site level support necessary to sustain HIV program impact over time.

SECTION 1: COP/ROP 2022 PLANNING LEVEL

Based upon current analysis of spend levels, information submitted for the End-of-Fiscal Year 2021 (EOFY) tool, and performance data, the total COP/ROP 2022 planning level is comprised as follows: Note – all pipeline numbers were provided and confirmed by your agency.

TABLE 1: All COP 2022 Funding by Appropriation Year

	Bilateral				Central				Total
	FY22	FY21	FY20	Unspecified	FY22	FY21	FY20	Unspecified	TOTAL
Total New Funding	$ 199,279,585	$ -	$ -	$ -	$ 3,800,000	$ -	$ -	$ -	$ 203,079,585
GHP-State	$ 198,029,585	$ -	$ -		$ -	$ -	$ -		$ 198,029,585
GHP-USAID	$ -				$ 3,800,000				$ 3,800,000
GAP	$ 1,250,000				$ -				$ 1,250,000
Total Applied Pipeline	$ -	$ -	$ -	$ 720,415	$ -	$ -	$ -	$ -	$ 720,415
HHS/CDC				$ 720,415				$ -	$ 720,415
TOTAL FUNDING	$ 199,279,585	$ -	$ -	$ 720,415	$ 3,800,000	$ -	$ -	$ -	$ 203,800,000

SECTION 2: COP 2022 BUDGETARY REQUIREMENTS AND OTHER CONSIDERATIONS**

Countries should plan for the full Care and Treatment (C&T) level of $101,378,900 and the full Orphans and Vulnerable Children (OVC) level of $42,267,000 of the PLL across all funding sources. These earmark levels on new funding are subsets of those amounts that must be programmed with specific types of funding due to Congressional requirements. The full amount programmed across all sources will be visible in the FAST.

TABLE 2: COP 2022 Earmarks by Appropriation Year*

	Appropriation Year			
	FY22	FY21	FY20	TOTAL
C&T	$ 101,378,900	$ -	$ -	$ 101,378,900
OVC	$ 42,267,000	$ -	$ -	$ 42,267,000
GBV	$ 7,944,200	$ -	$ -	$ 7,944,200
Water	$ 125,000	$ -	$ -	$ 125,000

*Only GHP-State and GHP-USAID will count towards the earmarks (Care and Treatment, OVC, GBV, and Water).

**Only GHP-State will count towards the GBV and Water earmarks

TABLE 3: COP 2022 Initiative Controls: Each dollar planned in COP can belong to only one initiative. Most COP funding will be budgeted as Core Program. In general, initiatives other than Core Program are used to track activities/programs that cannot be tracked by the combination of program area and beneficiary alone. See Appendix 1 for more detailed information on initiatives.

	Bilateral	Central	TOTAL
Total Funding	**$ 200,000,000**	**$ 3,800,000**	**$ 203,800,000**
Core Program	$ 125,011,728	$ -	$ 125,011,728
Cervical Cancer	$ 4,500,000	$ -	$ 4,500,000
Condoms (GHP-USAID Central Funding)	$ -	$ 3,800,000	$ 3,800,000
DREAMS	$ 40,277,472	$ -	$ 40,277,472
OVC (Non-DREAMS)	$ 13,210,800	$ -	$ 13,210,800
VMMC	$ 17,000,000	$ -	$ 17,000,000

TABLE 4: Programmatic Controls: Programmatic controls are used to track programmatic directives that can be tracked by a combination of program area and/or beneficiary. Programmatic controls may overlap with Initiatives, for example PrEP for Adolescent Girls and Young Women may count towards both the DREAMS Initiative and the PrEP (AGYW) programmatic control. See Appendix 1 for more detailed information on programmatic controls.

	Bilateral	Central	TOTAL
Total Funding	**$ 6,346,200**	**$ -**	**$ 6,346,200**
PrEP (AGYW)	$ 3,299,200	$ -	$ 3,299,200
PrEP (KPs)	$ 3,047,000	$ -	$ 3,047,000

TABLE 5: State ICASS Funding

	Appropriation Year
	FY22
ICASS	$ -

See Appendix 1 for detailed budgetary requirements and other budgetary considerations.

SECTION 3: PAST PERFORMANCE – COP/ROP 2020 Review

TABLE 6. COP/ROP OU Level FY21 Program Results (COP20) against FY22 Targets (COP21)

Indicator	FY21 result (COP20)	FY22 target (COP21)
TX Current <15	**52,085**	**69,976**
TX Current >15	**1,131,050**	**1,194,784**
VMMC >15	**127,194**	**133,955**
DREAMS (AGYW PREV)	**172,754**	**183,268**
Cervical Cancer Screening	**247,296**	**207,977**
TB Preventive Therapy	**214,864**	**275,844**

TABLE 7. COP/ROP 2020 | FY 2021 Agency-level Outlays versus Approved Budget

OU/Agency	Sum of Approved COP/ROP 2020 Planning Level	Sum of Total FY 2021 Outlays	Sum of Over/Under Outlays
ZIMBABWE	**$233,908,464**	**$215,878,898**	**$18,029,566**
HHS/CDC	$77,656,359	$73,400,824	$4,255,535
State	$718,046	$631,681	$86,365
USAID	$110,861,339	$97,745,204	$13,116,135
USAID/WCF	$44,672,720	$44,101,189	$571,531
Grand Total	**$233,908,464**	**$215,878,898**	**$18,029,566**

TABLE 8. COP/ROP 2020 | FY 2021 Results & Expenditures

Agency	Indicator	FY21 Target	FY21 Result	% Achievement	Program Classification	FY21 Expenditure	% Service Delivery
HHS/CDC	**HTS_TST**	472,587	**606,157**	128.26%	HTS Program Area	$4,716,910	94%
	HTS_TST_POS	29,454	**32,729**	111.12%			
	TX_NEW	26,945	**31,568**	117.16%	C&T Program Area	$29,072,402	67%
	TX_CURR	618,947	**570,330**	92.15%			
	VMMC_CIRC	130,369	**48,363**	37.10%	VMMC Sub-Program Area	$5,870,266	72%
	OVC_SERV	11,846	**25,207**	212.79%	OVC Beneficiary	----	---
USAID	**HTS_TST**	347,515	**645,574**	185.77%	HTS Program Area	$6,025,376	96%
	HTS_TST_POS	24,254	**39,313**	162.09%			
	TX_NEW	24,129	**36,869**	152.80%	C&T Program Area	$55,611,775	92%

	TX_CURR	661,214	**613,264**	92.75%			
	VMMC_CIRC	118,657	**78,833**	66.44%	VMMC Sub-Program Area	$9,219,837	100%
	OVC_SERV	439,164	**461,655**	105.12%	OVC Beneficiary	$14,139,812	90%
				Above Site Programs		$11,174,675	
				Program Management		$28,356,369	

SECTION 4: COP/ROP 2022 DIRECTIVES

The following section has specific directives for COP 2022 based on program performance noted above. Please review each section carefully including the minimum program requirements.

Minimum Program Requirements (MPR)
All PEPFAR programs – bilateral and regional– must ensure the following minimum program requirements are in place. Adherence to these policies and practices is essential to the success of all PEPFAR programs at the national, subnational, and service delivery levels (e.g. facility, school, community). Evidence demonstrates that lack of any one of these policies/practices significantly undermines HIV impact and results in inefficient and ineffective programs.

All PEPFAR programs are expected to meet all of the requirements below, and the COP22 Planning Meeting will include a review of the status of each requirement, including assessment of implementation (including barriers) at the point of client services. To the extent that any requirement(s) have not been met by the time of the COP22 Planning Meeting, the PEPFAR OU team will need to present a detailed description of existing barriers and the remediation plans proposed that will allow them to meet the requirement(s) prior to the beginning of FY2023. The list will be included in the Strategic Direction Summary (SDS), as well.

Failure to meet any of these requirements by the beginning of FY2023 may affect the OU budget. The minimum requirements for continued PEPFAR support include the table below.

TABLE 9. COP/ROP 2022 (FY 2023) Minimum Program Requirements

Care and Treatment
1. Adoption and implementation of Test and Start, with demonstrable access across all age, sex, and risk groups, and with direct and immediate (>95%) linkage of clients from testing to uninterrupted treatment across age, sex, and risk groups. Status: **Completed**
2. Rapid optimization of ART by offering TLD to all PLHIV weighing ≥30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children who are ≥4 weeks of age and weigh ≥3 kg, and removal of all NVP- and EFV-based ART regimens. Status: **Completed**
3. Adoption and implementation of differentiated service delivery models for all clients with HIV, including six-month multi-month dispensing (MMD), decentralized drug distribution (DDD), and services designed to improve identification and ART coverage and continuity for different demographic and risk groups. Status: **Completed**

4.	All eligible PLHIV, including children and adolescents, should complete TB preventive treatment (TPT), and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient. Status: **Not started (January 2022)** Issues or Barriers: TPT has been improving and scale up is going with a surge strategy. Implementation is expected to start January 2022.
5.	Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual viral load testing and results delivered to caregiver within 4 weeks. Status: **Completed** Completion of diagnostic network optimization has been achieved, but this is a moving target given the technology keeps evolving.
Case Finding	
6.	Scale-up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent should be offered testing for HIV. Status: **Completed**
Prevention and OVC	
7.	Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices) Status: **Completed**
8.	Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents living with HIV, 3) reducing risk for adolescent girls in high HIV-burden areas and for 10-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV. Status: **Completed**
Policy & Public Health Systems Support	
9.	In support of the targets set forth in the Global AIDS strategy and the commitments expressed in the 2021 political declaration, OUs demonstrate evidence of progress toward advancement of equity, reduction of stigma and discrimination, and promotion of human rights to improve HIV prevention and treatment outcomes for key populations, adolescent girls and young women, and other vulnerable groups. Status: **In-process** (No target date established) Issues or Barriers: PEPFAR Zimbabwe has made significant advancements supporting KP technical support committee, national prevention forums, DREAMS, etc. Structures have been embedded within the MoHCC and NAC to address these issues. Zimbabwe government institutions

now put key considerations for key and vulnerable populations in their guidance and are taking steps to advance equity and end stigma in their policy and guidance documents.
10. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services affecting access to HIV testing and treatment and prevention. Status: **In-process** (No target date established) Issues or Barriers: There has been progress on engaging some local authorities to forgo informal user fees. During COP21 meetings MoHCC committed to addressing issues as they emerge.
11. OUs assure program and site standards, including infection prevention & control interventions and site safety standards, are met by integrating effective Quality Assurance (QA) and Continuous Quality Improvement (CQI) practices into site and program management. QA/CQI is supported by IP work plans, Agency agreements, and national policy. Status: **Completed**
12. Evidence of treatment literacy and viral load literacy activities supported by Ministries of Health, National AIDS Councils and other partner country leadership offices with the general population and health care providers regarding U=U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention. Status: **Completed**
13. Clear evidence of agency progress toward local partner direct funding, including increased funding to key populations-led and women-led organizations in support of Global AIDS Strategy targets related to community-, KP- and women-led responses. Status: **Completed**
14. Evidence of partner government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended. Status: **In-process** (No set target date) Issues or Barriers: This is high priority for the PEPFAR Zimbabwe program. Ongoing work being done at the diplomatic and technical levels with strong coordination among other health development partners for joint advocacy.
15. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity. Status: **Completed**
16. Scale-up of case surveillance and unique identifiers for patients across all sites. Status**: In Progress** Issues or Barriers: A unique identifier established, EHR now generates a 36 digit Universally Unique ID Number assigned to everyone newly registered in the system. Scale up across all sites will begin January 2022.

In addition to meeting the minimum requirements outlined above, it is expected that Zimbabwe will consider all the following technical directives and priorities. A full list of COP/ROP 2022 Technical Priorities and Considerations are listed in COP guidance and can be referenced in Section 6.

Table 10. COP/ROP 2022 (FY 2023) Technical Directives

Zimbabwe Specific Technical Directives

Improve Viral Load Coverage and Early Infant Diagnosis	• Prioritize addressing the funding gap for VL commodities through continued stakeholder discussions and commitments • Standardize prioritization of VL samples for most at-risk clients including virally unsuppressed patients, pediatrics and key populations. • Continue to address laboratory system optimization and establish plan for VL equipment breakdowns, technology transitions for efficient resource use and time taken for repairs; including supporting VL specimen collection according to protocol balanced with commodities availability to process tests
Optimize PEPFAR Programs to achieve and maintain epidemic control	• Consider further opportunities to identify undiagnosed PLHIV through utilizing HTS screening tools aligned with PEPFAR program standards, leveraging HIV self-testing to expand the geographic reach of HTS, and routinely incorporating recency surveillance and other data into testing programing. • For COP22 and given that Zimbabwe is close to the 1st 90, PEPFAR should work intensively with MoHCC, GF and other stakeholders to promote PITC strategies that optimize testing coverage and case finding volume. Index testing should be universally offered to all PLHIV. Additionally, UNAIDS estimates that a large proportion of individuals who test HIV positive were previously diagnosed with HIV. As transition to MoHCC continues to advance, PEPFAR/Zimbabwe should consider implementing strategies to balance the need to minimize unnecessary testing while allowing HTS to be an entry point to ART re-engagement if necessary. • Optimize TB screening and reporting practices through the Targeted Universal TB testing strategy (TUTT) and continue to scale-up TPT initiation and completion • Continue, strengthen and expand successful implementation models to ensure continuity of treatment
Strengthen Prevention, Care and Treatment, especially for Key Populations and Pediatrics	• Consider a pediatric surge to identify, link and retain children and adolescents living with HIV in care to ultimately increase VLC/VLS. • Utilize community led monitoring to inform strategies, address equitable service access, and remedy bottlenecks to service, particularly for KPs. • Continue a strong focus on OVC-Clinical synergy to support linkage to treatment, retention and VLS; including supporting access to MMD and pediatric dolutegravir in partnership with other stakeholders. • The program has continued to improve reach and provide tailored prevention, care and treatment interventions for MSM and TG populations. Consider opportunities to continue to improve and ensure client centered services are scaled for these populations in addition to working with The Global Fund and other stakeholders to better understand the context and burden of HIV among people who use and inject drugs. • Consider opportunities in the DREAMS program to scale-up delivery of comprehensive economic strengthening interventions and enhance package of services for young women who sell sex (YWSS) and AGYW involved in transactional sex including direct service provision for male sexual partners.

Strengthen Health Systems	• Utilize new HRH inventory results with MER achievement, expenditure and other data to plan for optimal human resource allocations and staffing support. This will help ensure alignment of HRH investments with program priorities and guide future transitions. • Continue to further develop local partner capacity and leadership to support people living with HIV and HIV programming at local and national levels • Continue to expand EHR deployment to help enhance continuity of treatment and provide data for public health surveillance including HIV recent infections and comprehensive case surveillance. Consider enhancing partnerships with ongoing coordination among other donors, including Global Fund, for further investments in EHR and to ensure use and sustainability through capacitating structures, knowledge/skills, and a broader community of practice for knowledge sharing and resource mobilization.

Build Lasting Collaborations	• Continue engaging with development partners in a joint strategy to work with the government on initial planning to set the stage for sustaining impact over time. Additionally, consider opening a dialogue with development partners and Government of Zimbabwe on sustainable health financing options.
	• In collaboration with development partners, consider opportunities for private sector engagement in areas such as:
	  • Supply chain
	  • Distribution of drugs
	  • Service provision
	• Expand KP leadership and involvement in PEPFAR supported CLM; collaborate with the Global Fund and other stakeholders to support the national CLM working group to integrate CLM outputs into continuous quality improvement efforts.

PreP Scale-up

In COP 2022, PrEP should continue to be scaled up with a focus on ensuring policy and programmatic access to PrEP for higher incidence populations. Populations prioritized for PrEP should be tailored to the OU's epidemic context with a focus on Key Populations (including sex workers, men who have sex with men, transgender people, people in prisons and other closed settings, people who inject drugs), adolescent girls and young women including pregnant and breastfeeding AGYW, and other identified higher-incidence populations.

Addressing Structural Barriers to KP Service Delivery

COP/ROP 22 plans should prioritize and take specific steps to address the structural barriers that impede scale up of KP-led and KP-competent differentiated HIV services, as well as the lack of robust data to guide key populations programming. To strengthen strategic information to guide KP responses, plans may include efforts to strengthen individual level data systems and analyses and address gaps in subnational data. Addressing structural barriers should entail improving the enabling environment for HIV service delivery; mitigating harmful policy and social norms that fuel stigma, discrimination and violence faced by key populations; strengthening the capacity of key populations organizations; and strengthening the KP competency of HIV service providers. PEPFAR teams should ensure they are coordinating strategically with relevant State and U.S. government units (e.g. DRL), partner government, multilateral, and other donor funding streams and institutions. As part of the new COP 22 MPR,

PEPFAR teams will be expected to describe and present their approach to improving KP data and addressing barriers to accelerated KP-centered HIV services during COP/ROP 22 planning meetings.

Orphans and Vulnerable Children (OVC)

Minimum requirements for OVC programs include actively facilitating testing for all children at risk of HIV infection, and linkage to treatment and providing support and case management for vulnerable C/ALHIV. Based on FY21Q4 data, the proxy coverage of existing PEPFAR OVC programs in Zimbabwe is 107% for TX_CURR <15 and 61% for TX_CURR <20 in OVC PSNUs. True coverage falls somewhere in between these two estimates since the OVC program enrolls C/ALHIV 17 years of age and younger. While crude, the "proxy coverage" provides an estimate of how well OVC partners are doing at reaching C/ALHIV current on treatment in the same geographic areas where they are providing OVC program services.

It is important to also consider the total estimated coverage of OVC programs compared to the number of C/ALHIV current on treatment across the OU and supported by PEPFAR. For Zimbabwe, this is estimated at 49% for TX_CURR <15 and 28% for TX_CURR <20. As part of COP22 planning, all OUs with OVC programs should conduct analyses to understand how well the OVC program is geographically aligned with clinical programs/sites. OUs that do not already have a consensus definition for high-volume pediatric sites should reach out to their SI and PEDS, OVC liaisons for further guidance and support. Pending the results of these analyses, and key factors such as A/CLHIV population dispersion, shifts in geographic placement and target allocation for OVC partners may be necessary.

COP/ROP 2022 Active Engagement with Community and Civil Society (see section 2.5.3 of COP Guidance)

The full participation of community stakeholders and civil society in every stage of PEPFAR programming, planning, and monitoring, as appropriate and consistent with applicable law, regulations and policy, from advocacy to service delivery, is critical to the success and sustainability of PEPFAR and the global effort to combat HIV. Sustained control of the HIV/AIDS epidemic necessitates that PEPFAR teams actively and routinely coordinate and communicate with all partners, including local, regional, and international civil society and community stakeholders, multilateral partners and the partner country government.

Civil society organizations are essential and to be invited to participate in the virtual COP22 strategic retreats, planning meetings, as well as approval meetings. In particular, engagement with local CSOs at the country-level is required and should begin early and continue during the entirety of the COP planning, monitoring, and implementation process.

This engagement of civil society, including faith-based organizations/faith communities, specifically includes the sharing of FY 2021 Q4 and FY 2021 Annual Program Results (APR), analyses, and the convening of an in-country planning retreat with local stakeholders, no later than the week of February 7, 2022, in order to introduce and discuss all COP/ROP 2022 tools, guidance, results and targets as well as the proposed trajectory and strategy for COP/ROP 2022. The PEPFAR investments to support the national response must be planned intentionally with the Global Fund, with teams demonstrating how complementarity was achieved to ensure maximal impact on the HIV/AIDS epidemic is achieved.

In March 2022, PEPFAR will convene virtual meetings where outstanding decisions will be discussed and finalized. In addition to partner country representatives, the meetings will also include representatives from local and international civil society and community organizations, faith-based organizations/faith communities, private sector, and multilateral partners. Specific guidance for the 2022 virtual meeting delegations will be provided separately.

Engagement with all stakeholders is required beyond the meetings and throughout COP/ROP 2022 development, finalization, and implementation. As in COP/ROP 2021, the draft Strategic Direction Summary (SDS) is required to be shared with both CSO and FBO stakeholders for their input and comments at least 7 days prior to submission to S/GAC. Please refer to the COP/ROP 2022 Guidance for a full list of requirements and engagement timelines. In addition, a more detailed timeline for sharing key data visualizations and other information with stakeholders is forthcoming.

Community-led Monitoring (CLM)

In addition to prescribed and routine engagement during PEPFAR's annual business cycle, including around COP/ROP planning and quarterly POART processes, all PEPFAR programs are required to develop, support, and fund community-led monitoring (CLM) in close collaboration with independent, local civil society organizations and host country governments. Community-led monitoring in COP22 should build on prior activities in COP21 and be designed to help PEPFAR programs and health institutions pinpoint persistent problems, challenges, barriers, and enablers to effective client outcomes at the site level. In addition to being data-driven and action-oriented, CLM should continue to ensure indicators are defined by communities and health service users, and data should be additive and not a duplicate collection of routine data already available to PEPFAR through MER or SIMS. New in COP22, PEPFAR-supported community-led monitoring programs must include an explicit focus on key populations. CLM should be utilized to advance equity and to support improvement in programs, especially for populations who have not yet fully experienced the benefits of HIV epidemic control. For example, OUs with pediatric care and treatment programs should consider utilizing CLM to track and ensure accountability for child, adolescent, and family-centered care.

APPENDIX 1: Detailed Budgetary Requirements

Care and Treatment: Each OU's COP/ROP 2022 minimum requirement for the care and treatment earmark is reflected in Table 2. If there is no adjustment to the COP/ROP 2022 new funding level due to an adjustment in applied pipeline, countries must program to the full Care and Treatment earmark amount across new FY 2022 GHP-State and GHP-USAID funding. The Care and Treatment earmark will be calculated as the sum of the following:

- 100% Care and Treatment (C&T) Program Areas
- 50% Testing (HTS) Program Areas
- 100% Above Site Program: Laboratory System Strengthening
- 70% Pregnant and Breastfeeding Women Beneficiary Group
- Proportional % Program Management (Proportional Program Management will vary by mechanism and will be determined by the amount of other interventions at the mechanism that count towards the C&T earmark)

Orphans and Vulnerable Children (OVC): Each OU's COP/ROP 2022 minimum requirement for the OVC earmark is reflected in Table 2. Countries must program to the full OVC earmark amount across new FY 2022 GHP-State and GHP-USAID funding. The OVC earmark will be calculated as the sum of the following:

- 85% (DREAMS initiative funding — commodities planned under DREAMS initiative — Any HTS interventions planned under DREAMS initiative — Any C&T intervention planned under DREAMS initiative)
- 100% (OVC Beneficiary group funding — commodities planned under any intervention with OVC beneficiaries — Any HTS planned under interventions with OVC beneficiaries
- Proportional Program Management (Proportional Program Management will vary by mechanism and will be determined by the amount of other interventions at the mechanism that count towards the OVC earmark)

Abstinence, Be Faithful/Youth (AB/Y) Reporting Requirement: If AB/Y-programmed activities do not reach a 50 percent threshold of all sexual prevention funding, as calculated by the formula below, in any country with a generalized epidemic, S/GAC is required to report to the appropriate Congressional committees on the justification for the decision. Generalized epidemic countries which do not meet the 50 percent threshold must provide a brief written justification in FACTS Info, explaining the rationale for prevention programming decisions given the epidemiologic context, contributions of other donors, and other relevant factors.

Abstinence, Be Faithful/Youth (AB/Y) programming, formerly captured in the HVAB budget code, will now be captured by using a combination of prevention program areas and beneficiaries, which are identified in the formula below. The numerator captures those interventions that are Abstinence, Be Faithful/Youth (AB/Y) programming, and the denominator approximates all sexual prevention activities. The proportion of Abstinence, Be Faithful/Youth (AB/Y) programming as a proportion of all sexual prevention activities is calculated by dividing the numerator by the denominator:

Numerator

Prevention: primary prevention of HIV and sexual violence

(For OVC, OVC caregivers, young people and adolescents, children, young women and adolescent females, girls, young men and adolescent boys, and boys)

+

Prevention: community mobilization, behavior, and norms change

(For OVC, OVC caregivers, young people and adolescents, children, young women and adolescent females, girls, young men and adolescent boys, boys, adults, not disaggregated)

Denominator

Prevention: primary prevention of HIV and sexual violence (all populations)

+

Prevention: **community mobilization, behavior, and norms change** (all populations)

+

50 % Prevention: **Not disaggregated** (all populations)

Gender Based Violence (GBV): Each OU's COP/ROP 2021 minimum requirement for the GBV earmark is reflected in Table 2. Your GBV earmark requirement is calculated as the total **new FY 2022** funding programmed to the GBV cross-cutting code. Your COP/ROP 2022 earmark is derived by using the final COP/ROP 2021 GBV earmark allocation as a baseline. The COP/ROP 2022 planned level of new FY 2022 funds for GBV can be above this amount; however, it cannot fall below it.

Water: Each OU's COP/ROP 2021 minimum requirement for the water earmark is reflected in Table

2. Your water earmark requirement is calculated as the total **new FY 2022 funding** programmed to the water cross-cutting code. Your COP/ROP 2021 earmark is derived by using the final COP/ROP 2021 water earmark allocation as a baseline. The COP/ROP 2022 planned level of new FY 2022 funds for water can be above this amount; however, it cannot fall below it.

Initiative Controls: Table 3 shows initiative controls where S/GAC has directed funding for a set of activities that cannot be accounted for through program areas and/or beneficiaries alone. These controls can be exceeded without a control change, but a control change would be required before a lower level for these activities can be planned.

The four initiative controls below (**Cervical Cancer**, **DREAMS**, **OVC (non-DREAMS)**, and **VMMC**) have been assigned to the appropriate OUs. For OUs where these controls are designated in the PLL, the amounts reflect the minimum required. These initiative controls can be exceeded without a control change, but a control change request would be required before a lower level for these activities can be planned.

Cervical Cancer - This initiative provides funding for all activities related to cervical cancer screening and diagnosis and treatment of precancerous cervical lesions for women living with HIV as outlined in the COP Guidance.

DREAMS - The DREAMS initiative should capture all funding specifically allocated as DREAMS in the OU's planning level and must be used for the goal of HIV and sexual violence prevention among adolescent girls and young women (AGYW) ages 10-24 years (unless otherwise approved) in approved DREAMS SNUs in accordance with the DREAMS and COP Guidance. The DREAMS initiative can also include prevention interventions in DREAMS geographic areas for girls and boys aged 10-14 which may be cost shared with the OVC (non-DREAMS) initiative as noted in the COP guidance.
OVC (non-DREAMS) - OVC (non-DREAMS) is a new initiative in COP/ROP 2022. OUs should use the initiative to budget for OVC (non-DREAMS) programming, including all OVC comprehensive activities as outlined in the COP Guidance. The OVC (non-DREAMS) initiative should include ASP, SE, and PREV costs (except PrEP and VMMC) linked to any OVC beneficiary (including sub-beneficiaries such as OVC caregivers). As the initiative is new for COP/ROP 2022, OUs should pay particular attention to funds programmed under OVC (non-DREAMS) to ensure that the current cohort of children enrolled in the comprehensive program receive continuity of care for FY 2023. The OVC (non-DREAMS) initiative can also include prevention interventions for girls and boys aged 10-14 which may be cost-shared with the DREAMS initiative as noted in the COP guidance. The OVC (non-DREAMS) initiative cannot be met with any HTS, C&T, PM or commodities costs.

VMMC - All services and equipment related to providing surgical and ShangRing VMMC for boys/men ages 15 and above, and ShangRing circumcision only for boys age 13 and 14 years, should be budgeted using the VMMC initiative.

While the CLM initiative does not appear in PLL budget tables, as CLM remains a requirement in COP/ROP 2022 for all OUs, each OU is responsible for programming a portion of funds under the **Community-Led Monitoring** initiative.

Community-Led Monitoring - During COP/ROP 2020, PEPFAR invested in expansion of community-led monitoring, making it a requirement of all OUs, as a critical way to listen to community voices in assessment of program quality and design of client-centered services. Community-led monitoring remains a requirement in FY 2023.

In addition to the five initiatives above, S/GAC may also allocate funding to OUs under two additional initiative controls: **Condoms (GHP-USAID Central Funding)** and **One-Time Conditional Funding**. If the OU was designated to receive funding under either one or both these initiatives in COP/ROP 2022, Table 3 will reflect these amounts. Unless otherwise noted, country teams should meet these funding controls when programming in their FAST.

Condoms (GHP-USAID Central Funding) - This initiative control denotes the amount of GHP-USAID central funding the country team may use to procure male and female condoms, lubricants, and to ship these commodities to the OU. Any additional condoms and lubricants to be procured with PEPFAR funding should be budgeted in the FAST with bilateral funding.

USAID Southern Africa Regional Platform - This initiative is for the country's share of the costs to operate the USAID Southern Africa Regional Platform, which provides administrative and technical support for Angola, Botswana, Eswatini, Lesotho, and Namibia. These funds were previously planned as part of the bilateral COP funding, but are now budgeted and notified centrally, with country amounts included as central funding in the overall COP levels for Angola, Botswana, Eswatini, Lesotho, and Namibia. Only these 5 countries may use this initiative, and this initiative can only be used with central funding specifically provided as part of the PLL controls.

One-Time Conditional Funding - The release of any funding made available under this initiative is contingent upon the OU's ability to meet all requirements outlined in their final COP/ROP approval memo. OUs that fail to meet these minimum standards may be ineligible to receive these funds for programmatic implementation in FY 2023.

No control is set in the PLL for the **HBCU Tx** and **Surveillance and Public Health Response** initiatives, but OUs may include relevant funds under these initiatives instead of Core Program as appropriate.

All funding not attributed to one of the nine COP/ROP 2022 initiatives above should be attributed to the **Core Program** initiative.

For additional details on initiatives, see the PEPFAR Financial Classifications Reference Guide.

Programmatic Controls: Table 4 shows programmatic controls where S/GAC has directed funding for certain programmatic activities. These controls can be exceeded without a control change, but a control change would be required before a lower level for these activities can be planned. Since every dollar programmed in COP must belong to one initiative, programmatic controls will be a subset of one or more initiative controls, even if the standard Core Program initiative.

PrEP (AGYW) – The PrEP (AGYW) programmatic control tracks all funding budgeted under the Prevention – PrEP program area and sub-program area for the Females – Adolescent Girls and Young Women sub-beneficiary. The control encompasses both service delivery (SD) and non-service delivery (NSD) activities, inclusive of any commodities costs. OUs should tailor the distribution of funds to SD and NSD based on the country context prioritizing the provision of PrEP services and increasing the number of AGYW on PrEP wherever possible. Countries with a PrEP (AGYW) control should expect to program no more than 10 to 30 percent of their control as non-service delivery.

PrEP (KPs) – The PrEP (KPs) programmatic control tracks all funding budgeted under the Prevention – PrEP program area and sub-program area for all sub-beneficiaries under the KP beneficiary. The control encompasses both service delivery (SD) and non-service delivery (NSD) activities, inclusive of any

commodities costs. OUs should tailor the distribution of funds to SD and NSD based on the country context prioritizing the provision of PrEP services and increasing the number of KPs on PrEP wherever possible. Countries with a PrEP (KPs) control should expect to program no more than 10 to 30 percent of their control as non-service delivery.

State ICASS: Table 5 shows the amount that the OU must program under State for ICASS Costs.

Funds Programmed under State/SGAC (S/GAC TBDs)

No funding may be programmed under State/SGAC without prior approval from S/GAC M&B. In general State/SGAC TBDs are only used in extraordinary and or unusual circumstances. To the degree that funding is approved, the rationale and any conditions attached to the funding will be documented by M&B. Any S/GAC TBDs approved during COP/ROP 2022 planning will require supplemental language in the OU's COP/ROP 2022 approval memo, clearly outlining the process for how these funds can be accessed. Any funds that have not been distributed to agencies before the end of FY 2023 may be subject to reprogramming in future planning cycles towards the same OU or another OU.

COP/ROP 2022 Applied Pipeline (See Section 9.1.2 Applied Pipeline of COP Guidance)

Whenever possible, all agencies within an OU should hold several months of pipeline at the end of COP/ROP 2022 implementation in order to ensure sufficient funds and prevent disruptions in service delivery in the event of funding delays. If an agency/OU combination has a history of over-outlays, or in cases where an agency/OU COP envelope has increased in recent years, there may not be sufficient funding to maintain this buffer. With the exception of Dominican Republic, Ethiopia, Haiti, South Sudan, Zimbabwe, Asia Regional Program, and Western Hemisphere Regional Program, which should hold up to four months of pipeline, all other OUs are permitted to hold no more than three months of buffer pipeline.

Any agency that anticipates ending COP/ROP 2021 implementation (end of FY 2022) with a pipeline in excess of three or four months is required to apply this excessive pipeline to COP/ROP 2022, decreasing the new funding amount to stay within the planning level.

Transitioning HIV Services to Local Partners

To sustain epidemic control, it is critical that the full range of HIV prevention and treatment services are owned and operated by local institutions, governments, and organizations – regardless of current ARV coverage levels. The intent of the transitioning to local partners is to increase the delivery of direct HIV services, along with non-direct services provided at the site, and establish sufficient capacity, capability, and durability of these local partners to ensure successful, long-term local partner engagement and impact. This action is a priority for all OUs, Regional Programs and Country Pairs. In COP19 Guidance, PEPFAR set a goal that 40% of partners must be local by the end of FY19, and 70% by the end of FY20.While considerable progress was made in this effort, the 70% mark was not achieved by all agencies in all OUs, and thus in FY22 and FY23, teams must continue to prioritize this so that the 70% goal can be realized. Each country has to contribute to this goal based on the context of the local partner mix and types of public and private partners available to provide essential services. Therefore, each OU agency should work with their respective agency HQ in determining their contribution in meeting the agency level local partner requirement for FY23 as appropriate through their COP/ROP 2022 submission.